Is it Neurosis?

JOHN PETERS, M.D., *Los Angeles*

• *So-called "minor psychiatry," the treatment of neurosis in persons who are not psychotic, may well be undertaken by the general practitioner.*

The first duty of the physician in dealing with a neurotic person is to determine whether psychosis may develop. He must be patient and thorough in hearing the history of the case and should have full information on the patient's life and family.

A recent classification of the neuroses is given and the more generally recognized symptoms of these conditions are described.

FOR SEVERAL YEARS, according to Levine,[2] it has been possible to speak of "major psychiatry" and "minor psychiatry" as we speak of major and minor operations. The major surgical procedures should be undertaken only by those who are fully trained and experienced, but it is recognized that there are also certain types of operation which can be performed by the practitioner with less specialized training with equally satisfactory results. An analogous situation exists in psychiatry: The great majority of nervous conditions fall into the "minor" category and do not require treatment by a specialist. This presentation is an attempt to give information that may be of value to the general practitioner in determining whether a patient has a functional disorder (neurosis).

It has been firmly established that every emotional conflict has some physiologic or organic concomitant, and it is also true that every organic disturbance causes emotional symptoms. Alexander[1] put it well when he said that theoretically every disease is psychosomatic since emotional factors influence all body processes through nervous and humoral pathways. He cited common physiological processes such as weeping, sighing, laughing, blushing, gesticulating and grimacing which can take place only under the influence of specific emotional situations.

Watts and Wilbur[4] recently stated that any diagnosis in patients with functional disorders requires identification of symptom complexes resulting from functional disorders as well as from organic disease. Although they used the word "functional" throughout their discussion it is obvious that they were referring to disorders stemming from neurosis.

In recent years the terms "neurosis," "psychoneurosis," and "psychoneurotic reaction" have become synonymous. All denote physiologic reaction to situational problems. It has been said that neurosis does not deny the existence of reality, it merely tries to ignore it. The reactions are unconsciously motivated, or at least they are out of voluntary control. The symptoms reflect individual ways of reacting to specific stresses and they vary according to constitutional equipment and experience of life. Neurosis stems from efforts to deal with specific difficult and anxiety-producing emotional problems. It is well to remember that all persons have emotional symptoms, but it is only when the symptoms are bothersome, or cause anxiety with physiological changes, that it becomes necessary to remedy them.

In dealing with a patient having symptoms of neurosis the most important thing for the physician to determine is whether the condition might develop into psychosis. In neurosis there is but little disorganization of the personality, whereas in psychosis the disorganization is relatively great. The inner experiences of a neurotic person do not upset the external behavior, but the behavior of a psychotic person may be entirely abnormal. It should be noted, however, that a diagnosis of psychosis can never be made on the basis of behavior alone. The thought content must be considered along with behavior deviations. In neurosis the grasp of social relations is not disturbed and there are no real delusions, whereas in psychosis frequently social adjustments are destroyed and true delusions occur. A person who is only neurotic has no disturbances of associations; there is no consistent or lasting deterioration of the intellect; insight is usually good and regression is not present or is only slight. In contrast, in psychotic persons, associations usually are distorted or impaired; deterioration of the intellect may be pronounced; usually insight is lacking, and, as in senile or paretic patients, regression may continue to the infantile level.

CLASSIFICATION

The general practitioner may have no great interest in the formal classification of the neuroses. However, one can recognize only that with which he is

From the Department of Psychiatry, Section on Nervous Diseases, College of Medical Evangelists, Los Angeles.

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familiar. If a person knows little or nothing about the shadings in an x-ray film he will learn little or nothing from them. If signs of pathologic changes are pointed out to him in a film, he may recognize them but will still be unable to associate them with the total picture.

Applying the same logic to skin diseases, it becomes clear that the physician must know the type of rash or lesion to be expected before he can get a good idea of the diagnosis. This may be quite difficult at times. Differences of opinion may be expressed by even the most skilled of diagnosticians, but if they have sufficient knowledge of the classification of the diseases, diagnosis is made easier. Differences of opinion do not imply that a classification is not desired. Systematic arrangement tends to make for a more rapid absorption of content material.

The latest classification of the neuroses has appeared only recently. Doubtless the old terms will continue in use for many years to come. But no matter what nomenclature is adopted by the American Psychiatric Association, every effort should be made to adhere to the terms selected. This uniformity averts the misunderstanding and confusion which would otherwise result from the use of different terms by various groups or persons.

OLD TERMS	NEW TERMS
1. Hysteria	1. Anxiety reaction
a. Anxiety	2. Dissociative reaction
b. Conversion	3. Conversion reaction
2. Psychasthenia	4. Obsessive-compulsive reaction
3. Neurasthenia	5. Depressive reaction
4. Hypochondriasis	6. Phobic reaction
5. Reactive depression	7. Psychoneurotic reaction, other.
6. Anxiety state	
7. Mixed types	

The American Psychiatric Association has recently published a manual which includes the new nomenclature and indicates the old where changes have been made. Students of psychiatry will wish to consult this manual whether they are specialists or general practitioners. "Neurasthenia" and "hypochondriasis" are replaced by a new classification known as "psychophysiological reactions." "Anxiety reaction" replaces the old "anxiety hysteria" and "anxiety type." "Conversion reaction" replaces "conversion hysteria." "Obsessive-compulsive reaction" replaces the psychasthenias, and "depressive reaction" replaces "reactive depression." "Psychoneurotic reaction, other" permits other classifications if the examiner cannot place his findings in any of the stated categories. It replaces "mixed" type in the old classification. "Dissociation," as described by Noyes, is a mechanism to the employment of which the organism may resort in order to secure a measure of satisfaction when various components of the personality are not well integrated. An aspect of the personality that is a source of emotional distress may thus be eliminated. Examples of dissociation are sleep walking, automatic writing, fugues and multiple personalities.

ETIOLOGY

An accurate diagnosis cannot be made without some idea of the causative factors. Books have been written in an endeavor to show that a neurotic patient is neurotic because he has a poor hereditary background, and still other books have been written to show that what happens to a person after he is born constitutes the deciding factor in the development of neurotic traits. It is reasonable to assume that both heredity and environment play a part. The constitutional factors may be compared to soil which may be rich or poor in qualities which make for the development of neurotic traits or tendencies; and the happenings of life, whether stresses, strains, tensions, conflicts, guilts, wishes, frustrations or violations of taboos, may be likened to the seed.

Continuing the analogy, it is recognized that there must be soil and there must be seed, and the seed must be dropped in the soil before there can be a disruption sufficient to disturb the person's tranquility. Emotional factors cannot be ignored as causes in the development of a neurosis, but neither can the constitutional equipment be passed over lightly. Many adherents to the psychoanalytic approach to the neuroses believe that they are basically derived from the conflicts that arose in childhood. Other experts differ with this theory. Probably everyone will agree that without psychological conflict neurotic symptoms would never develop sufficiently to cause disability.

SYMPTOMS

It has been said that a hysterical patient may have symptoms simulating those of any disease. This may be an exaggeration, but it gives an idea of the wide variation in symptoms in hysteria. The disturbances may be sensory, motor, visceral or mental. Where there is a multiplicity of somatic complaints without substantiating physical findings, or with bizarre findings, the diagnosis of hysteria must be considered. When anxiety, worry, fright, startle patterns and panic reactions are predominant, anxiety reaction is a more likely diagnosis. If there are compulsions, obsessions or phobias, the classification of obsessive-compulsive reaction is obvious. (A *phobia* is an intense fear associated with an idea, object or situation which tends to recur. *Obsessions* are thoughts of a distressing or unwelcome nature that tend to recur and are regarded as defensive in pur-

pose. *Compulsions* are usually confined to some action performed under an irresistible urge.)

The depressive reaction deserves special comment. It is always directly associated with some disturbing event in the life of a person who has been somewhat neurotic for years, and may follow a disappointment in love, financial reverses, severe illness, divorce, a death or any emotionally charged situation. There is always the possibility of suicide in such a case, and for this reason consultation should be obtained early, not necessarily with a psychiatrist but with any other physician.

DIAGNOSIS

No diagnosis of neurosis can be made without a good history of the case, and the physician should not expect to get a good history without devoting considerable time to listening. In many cases the diagnosis can be made, or at least a good lead obtained, by listening alone. It may be necessary to interject leading questions at certain points in order to get a longitudinal view of the patient. The physician must strive to get as much information from the patient, friends or relatives as possible, and this background must include the family history back at least as far as the grandparents. An attempt should be made to determine whether the childhood was happy or not, and whether the patient felt that he was loved, wanted and secure.

Certain highly significant traits have been designated as the "neurotic stigmata" of childhood. Any child may have some of them, but if a child has more than four or five it is quite probable that neurosis will develop. These traits are:

Fainting attacks
Nail biting or picking
Temper tantrums
Worry
Dizziness
Handicaps: crossed eyes, harelip, limp, etc.
Sleepwalking
Sulking
Enuresis
Stammering
Thumb or finger sucking
Slow to walk or talk
Convulsions
Nightmares
Habit spasm
Tics
Fears of: Dark, storms, heights, crowds, closed places, animals, etc.

The physician should ascertain whether, as he grew older, the patient had a tendency to be shy, bashful, forward, seclusive, asocial, moody, depressed, or eccentric or had crying spells, whether it was easy or difficult for him to make and hold friends, develop hobbies and get along with others, and if not why not.

The following neurotic traits, although they sometimes occur in children, are more often observed in adults:

Headache	Backache	Muscle ache
Globus	Twitchings	Dermographia
Hyperhidrosis	Head noises	Insomnia
Formication	Tenseness	Anxiety
Introspection	Apprehension	Palpitation
Heart consciousness	Dyspnea	Numbness
Tremors	Anorexia	Fatigue

A few points in which neurotic symptoms differ from those of an organic nature should be kept in mind. If a patient has paralysis of some kind over which he has but little concern or anxiety, a functional element is to be suspected. When the complaint is of fatigue out of all proportion to the amount of physical effort performed and not owing to organic causes, neurosis should be considered. The time of onset of anxiety-producing symptoms is important, as there may have been some definite, unusual event which occurred such as head injury, personal loss, fever, infection, etc. The physician should be quick to note whether the symptoms are out of all proportion to the trauma, physical or mental, and to learn if the patient ever injured himself previously in a similar way. The inferences to be drawn are obvious.

Finally, it must always be remembered that there is no substitute for a thorough physical examination, whether it be for diagnosis or for therapy in neurosis.

312 North Boyle Avenue.

REFERENCES

1. Alexander, F.: Psychosomatic Medicine, W. W. Norton and Co., New York, 1950.
2. Levine, M.: Psychotherapy in Medical Practice, The Macmillan Co., New York, 1942.
3. Noyes, A. P.: Modern Clinical Psychiatry, W. B. Saunders Co., Philadelphia, 1948.
4. Watts, M. S., and Wilbur, D. L.: Clinical management of "functional disorders," J.A.M.A., 148:704, 1952.